PARISH MINISTERS AND THE TERMINALLY ILL

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by

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ABSTRACT

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In this world God has called forth the possibility of life. That possibility carries with it great risks, for it also calls forth the possibility of suffering. So it is, in the midst of life, people experience joy and pain, celebration and sadness, life and death. As ministers seek to serve those within their congregations, they find themselves ministering to the terminally ill and to their families.

This paper explores the principles which can undergird a pastor's work with those who are terminally ill. It begins, in Chapter 2, by discussing the relationship between God and the suffering that occurs in the world. It considers the tension involved in thinking of God as both all powerful and all loving.

The next three chapters examine in turn the work of Elisabeth Kuebler-Ross, the contemporary Hospice movement, and Mother Teresa of Calcutta. Each chapter begins by surveying the history of one of these. It then deduces and evaluates the motivating principles involved and applies them to parish ministry.

Based on the theological reflections in Chapter 2 and what has been learned from Kuebler-Ross, the Hospice Movement, and Mother Teresa, Chapter 6 proposes principles for pastoral ministry with the terminally ill. These do not provide answers to all the questions that can be asked, but they do offer an elastic framework that can be adapted to the needs of particular people.

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CHAPTER 1

Introduction

This project seeks to give pastors ideas for ministering to terminally ill patients by evaluating three contemporary models of service to the terminally ill, and using those models to inform parish pastoral care.

Importance of the Problem

The mid-1960's saw the advent of a crisis of care for the terminally ill. As medicine made gigantic leaps forward following Word War II, care for people nearing death changed. In previous years it was likely that persons with protracted illnesses would die at home, often surrounded by loved ones. In the 1960's it was more likely that people would die in the hospital, often alone, hooked up to machines that prolonged life. As illness progressed, patients and families found themselves caught up in a whirlwind of tests and procedures. Often hours were spent waiting for a test to be performed. There was the travel from doctor's office to hospital to lab. In some areas people had to travel great distances to reach a place where the proper equipment for tests or treatment was available. As families and patients found themselves caught up in these activities programmed by doctors and therapists, they began to experience a loss of control over their lives.

As treatment focused more and more on the disease, there seemed to be less and less focus on patients as people with needs. Soon, there evolved the possibility of patients and their families having no one with whom to talk or to share concerns, unless one wanted to talk about miracle drugs and cures. Further, there comes a point where even though treatment continues, there is little, if any, hope for survival.

In 1964 Margaretta Bowers and others wrote a book entitled Counseling the Dying.[1] In this book the authors posed many questions concerning the care of the terminally ill. Some of their questions concerned the isolation of the terminally ill, the continuation of treatment at certain stages of illness, and the practice of hospitalizing patients who could have been cared for at home. The book suggested that those who are uncomfortable working with the dying are still coming to terms with their own death.

In the early 1970's Dr. Elizabeth Kuebler-Ross' first books were published. Her work, along with interest in the European Hospice Movement stirred debate on the care of the terminally ill and their families. Much has been written since concerning the needs of those who are experiencing protracted death first hand.

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[1] Margaretta Bowers, et al., Counseling the Dying (New York: Nelson & Sons, 1964). This basic book on counseling the dying raised many questions later practitioners decided to pursue. It provided basic reflections on why working with the dying person is important and dealt with many questions raised by counseling the dying.

The issue of relating to the terminally ill is still very alive today. Pastors who work in parishes are confronted with the needs of the terminally ill and their families. The parish minister's position differs from the medical personnel who work with patients. The pastor may have ministered to the sick person for years before the illness was discovered and may continue to serve the family long after the patient dies. Beside the longevity of the relationship, the pastor adds a spiritual dimension. Acting as representative of the Community of Faith, (the church), and as a representative of God, the minister has the opportunity to share concerns of the patient and family that they might not feel comfortable sharing with anyone else.

Pastors can learn much from the writings and methods of those who pioneered and continue to develop modern ideas and methods for helping the terminally ill. It is important when studying another's system to understand that system's underlying principles, and to evaluate the appropriateness of these principles for use in the parish setting.

Definition of Terms

To aid in the understanding of the concepts in this paper, two basic terms will be defined. Those terms are: terminally ill, and principles.

Terminally Ill

Terminally ill patients are those persons suffering from a disease: (1) from which there is no cure, and (2) which is

serious enough to cause death. Examples of such forms of illnesses include cancer, AIDS, and leukemia. For purposes of this paper, "terminally ill" shall refer only to those patients currently suffering the effects of their illness. It will not include those who are in remission.

Principles

Principles shall be defined as the underlying assumptions which motivate and give shape to the work done by the organizations that deal with the terminally ill.

Limitations and Scope

James Ewens and Patricia Herrington edited a book in 1983 entitled Hospice: A Handbook for Families and Others Facing Terminal Illness. In their dedication they speak of,

> the pioneer efforts made by three women who differ in age, place of birth, religious outlook, and level of education. One (Dr. Kuebler-Ross) began her career in Switzerland, another (Mother Teresa) in India, a third (Dr. Saunders) in England . . . Together, over ten years time, they have changed the attitude and perception of the world in regard to those who are dying.[2]

This paper shall be limited to looking at those three current systems for serving the terminally ill. Again, these systems are: (1) the work begun by Elisabeth Kuebler-Ross, (2) the Hospice Movement, which gained impetus from the work done by Dr. Saunders, and (3) the work of Mother Teresa of Calcutta. In successive chapters the history of each of the

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[2] James Ewens and Patricia Herrington, eds., Hospice: A Handbook for Families and Others Facing Terminal Illness (Santa Fe: Bear & Co., 1982), 10.

systems will be summarized together with an analysis of their principles and applications to parish ministry.

The perspective from which the principles are analyzed comes from the author's reflections concerning God's power and presence in the world, and how that relates to the issue of illness and suffering. These reflections are detailed in Chapter 2.

Library research comprises about fifty percent of the work presented in this paper. About one quarter of the paper is original thought in the form of theological reflection. The rest of the paper consists of case studies reflecting how certain principles are or are not effective in parish ministry.

Chapter Outlines

The second chapter, "Theodicy: The Relation of God to Evil," seeks to discover the relationship between God and the suffering that occurs in this world. The chapter explores the nature of God by discussing the dichotomy between God being all powerful or all loving. God's ability to effect change in the world is suggested as in interpretation of the power of God. The chapter concludes with a look at whether God is responsive to people and interacts with them.

Chapter 3, "Elisabeth Kuebler-Ross," looks first at the history of the work done by Dr. Elisabeth Kuebler-Ross. Kuebler-Ross' work with the terminally ill, from immediately following World War II, to her work at Chicago, to her

retreat in California, is surveyed. Following this survey three principles basic to the formulation of her system are discussed. The chapter concludes with an evaluation of those principles, and application to parish ministry.

Chapter 4 deals with the Hospice Movement in England and the United States. Following the presentation of the history of the Hospice Movement, three basic principles are discussed. Finally there is an evaluation of those principles and application to parish ministry.

Chapter 5, "A Spiritual Perspective: A Look At Mother Teresa of Calcutta," describes a third approach to working with the terminally ill. A history of Mother Teresa's work is presented, along with the formulation of her basic principles. Each of the principles is critiqued, and applied to parish ministry.

The final chapter, Chapter 6, presents principles to help pastors in their ministry to the terminally ill and their families. These principles are based on the theology outlined in Chapter 2, and on the principles evaluated in the other Chapters.

CHAPTER 2

Theodicy: The Relation of God to Evil

As one sees the terrible human waste that occurs because of suffering, one looks again at the doctrine of God as "all powerful." If God is a loving God, and also an all powerful God, why is there so much suffering and evil in the world?

One method of resolving the problem is to hypothesize a cosmic dualism. God, representing the "good" moral forces of nature, is in constant battle with Satan, representing the "Evil" moral forces of nature. God, who is all powerful and loving, allows this cosmic dualism to exist. All human evil and natural evil, including illness, calamity, and natural disaster, are directly attributed to Satan, or the Evil forces that are at work in the world. In this view the dualism that divides creation into Good and Evil will only be abolished at the close of time, when God and the forces of Good shall defeat Satan and the forces of Evil for all eternity.[1]

One of the components of Christian dualism is the understanding that God allows the dualism to exist. This allows

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[1]Henry Clarence Thiessen, Lectures in Systematic Theology, Revised ed. (Grand Rapids: Eerdmans, 1979), 38f. Gives a brief history of the development of dualistic theology.

the existence of Evil to be explained without negating that God is all loving or all powerful. The problem with this line of reasoning is that it really does not describe an all loving God, or an all powerful God. A God who chooses to be limited by Evil may not be all good. It is difficult to call "good" a God that would allow the tragic human waste that occurs if God were capable of stopping it. It is impossible to look into the eyes of children who have been brutalized by parents, relatives, or friends, and say that God would have allowed such brutalization if that loving God had the means to stop it.

If dualists argue that God is all loving, then it becomes difficult to argue that God is all powerful. A loving God would put a hasty end to the battle between Good and Evil. Since that battle continues, God's power is limited by the continuing presence of Evil within the world.

Another method of reconciling an all powerful God with the existence of human evil uses a "free will" model of discussion. Yes, it would be possible for God to create human beings to be completely devoid of sin, but it is more important for God to give humans free will. With freedom to choose to do the will of God, or freedom to disobey God's will, comes the possibility of an open and accepting relationship between persons and their God.[2] The love

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[2] Stephen Davis, ed. "Free Will and Evil," Encountering Evil: Live Options in Theodicy (Atlanta: John Knox, 1981).

humanity bestows upon God is a love that is freely chosen by humanity, and therefore somehow more desirable to God. This free will, is even still desirable when balanced against the suffering it creates. This is not an all powerful God who cannot create freewilled, yet somehow intrinsically good people. The freewill God of this model is limited by the very nature of reality, that free will means the possibility of evil. If God's limitation is again, inherent, or part of the very nature of God, then God cannot be all powerful. If, however, God's limitation is self-imposed, it is hard to reconcile an all loving God with a God who has created a world where some people will never experience any love at all.

A Loving God and a Suffering World

When our reflection about God begins with the question of power, we get in trouble. But there is another approach. The Christian faith is based on the fundamental belief that in and through the life of Jesus Christ, God was revealed in the truest way possible. In the Gospel of John the reason for the revelation through Christ is expressed. "For God so loved the world, that he gave his only begotten Son."[3] One basic premise of the Christian faith is that God loves the world. Although, at times, that love may be undeserved, it is the very nature of God. Love is not something God decides

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[3] John 3:16a (RSV).

to do, or be, whenever God is in the mood, it is the very nature and substance of God. Such a word as "love" falls short, however, of describing the nature of God. The word itself has become trapped in the human predicament, and been weakened by grasping and suffocating self-love (which is not really love at all). The love that God extends is love that frees and enables. It calls us forth, out of ourselves, into the possibility of selflessness and caring.

"In the beginning God created the heavens and the earth. The earth was without form and void, and darkness was upon the face of the deep; and the spirit of God was moving over the face of the waters."[4] The image of creation, as presented in the first chapter of Genesis, is not the image of God creating something out of nothing. Rather, it is the image of God creating form out of formlessness, of taking chaos and disorder, and creating order. Those who live in close association with nature understand this distinction. In nature there always seems to be the possibility of the world slipping back into disorder. Any number of natural disasters, volcanos, tidal waves, etc. present the possibility that the balance of nature which nourishes life can be upset.

The power of God is to call forth, from the chaos, and through evolution the wonders and mysteries around us. While

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[4]Genesis 1:1-2 (RSV).

natural selection carries the species on earth, in humans, the voice of the Creator has called forth beings that have a soul. In a world in which suffering is not only possible, but probable, God has called forth the possibility of "being." Being, is not only the possibility of breathing, and living, and dying, but it is the possibility of being "a little less than the angels." The possibility of being like God is the possibility of loving.

That possibility carries with it great risks, for within this world, in which God has called forth the possibility of being, there is also the probability of suffering. Since an all loving God would, if it were possible, create the possibility of being without the probability of suffering, it follows that the creation of being cannot be accomplished except in the context of the probability of suffering.

Since the Christian faith believes that, in and through the life of Jesus Christ, God has been revealed in the truest way possible, one can look at the life of Christ to gain some understanding of God and the issue of powerfulness. Through the life of Jesus is revealed God's point of view, that the power of God is the power of powerlessness. From the beginning of his ministry, Jesus is depicted as refusing to use force or showmanship. As Jesus is in the wilderness, being tempted, he first refuses to turn stone into bread to satisfy his own physical needs. Then, he refuses to hurl himself from the top of the temple towers to test the love God has

for him. Finally, he refuses to sieze power over the kingdoms of the world by worshiping his tempter.[5] From the beginning of Jesus' ministry, to the end, when he hangs crucified on a cross, God forsakes the power of the world.

A popular song, detailing the events of Good Friday stirringly proclaims the words . . . "He could have called ten thousand angels . . . ."[6] From God's viewpoint, that is not true. Just as he could not open his ministry with an overwhelming display of power, God could not have closed Jesus' ministry that way. God instead submits to the cross.

But, the story doesn't end there, for the crucifixion was not God's final word. The Resurrection completes our image of God, and gives an expression of Hope. The message that Christ proclaimed is true, the Kingdom of God, the very presence of God is with us in and through all things. Though love may not seem the strongest force, it is indeed a force with which to be reckoned. Love is a force that extends beyond the boundaries of hate and even the boundaries of death.

The Power of God's Grace

There are two ways that God's grace reaches out to people. First, it accepts us. God's grace, empowered by love, reaches out to people in all times and circumstances,

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[5]Mathew 4:1-11.

[6]Ray Overholt, "Ten Thousand Angels," Lillenas Pub., 1959.

and seeks to have them realize that God cares for them. It is this accepting grace of God that enables God to take the risk of creation, to call forth people into existence even when that existence includes the possibility of suffering and evil.

The second way that God's grace reaches out to people shows the power of God that is not the power of exercise control, but the power to effect change. Something that effects a change is often called a catalyst. In science, a catalyst is an agent that, when combined with two other agents, causes the last two to be changed. In such chemical reactions, the catalyst remains unchanged. While the example is not perfect, it does illustrate how just the presence of God in the world can create possibilities that would not be possible without the presence of God.

God's power to effect change, to call people out of their own self-interests into an attitude of maturing other interestedness, is based in the very nature of God, which is love. While there may, at times, seem to be more powerful forces within this world than the power of God's love, that very love still remains a strong agent within the world. That love of God, which inspires hope in the human heart, enables individuals to see themselves as God sees them, that is, as people of value and worth, as subjects rather than objects. That hope, based on the accepting love of God, becomes the empowering love of God that calls people to growth

and change. That power of God can be illustrated in the life of adults whose parents early on instilled a sense of self-worthlessness. It is those adults who come to church hoping against hope that their parents were wrong, and that just perhaps, God could find something worth saving in their lives. The power of God's love seeks to inspire the dignity and worth of every human being.

God's power is also evident in the mysterious nature of God. There comes a point, when after words have been used, that the description of the power of God stops. There is still a mystery about God, that we can not yet grasp or understand. God's power, for change, is limited in the ways previously described. Yet in many ways, God's power is greater and more mysterious than its limitation. We humans, during our life on this earth, are bound to the physical and temporal. Though at times, we sense the winds of eternity that blow through our lives, we are creatures of this world. Though we are people of the spirit, we are also people of the flesh, who live and breathe and seek to make our place in this world. Yet we are not totally bound to it. This then expresses the Christian hope, that in the end the persuasive power of God's love will complete creation and bring about the Kingdom of God.

The Responsiveness of God

When one proves the very nature of God, one also deals with the question of God's responsiveness to the human

predicament. Is God immutable, unwavering, unresponsive to the joys and pains of the people who populate the earth? Or is God in relationship to people? Does God rejoice in our joy and join in suffering with us when we suffer?

Let this first question be set aside for a moment to look at a related question. Does God's purpose or "plan" for an individual change, or is it changeless? This question makes the assumption that God does have a plan for everyone. However, this need not imply a pre-set script that God writes for each person's life and then expects that individual to follow.

Instead, God wishes for each person maturity and spiritual growth. This reflects the power of God's grace to effect change. For example, imagine a woman at age 25 whose best use of her talents and the position of greatest growth would be to take vows of celibacy and poverty and become a nun. Suppose, however, this woman marries instead and by age 30 has two children. The situation has changed, the woman has changed, and God's goals for that individual have changed.

Can God's plan for an individual change? The answer is yes. If, then, God's goals and relationship with us change, it is not a great jump of logic to conclude that God is responsive to us and that God is affected by the lives we lead.

On a more basic level, to interact implies movement.

For people to talk together, they must first gather at a common location, listen to each other speak, and form their thoughts in such a way they can be communicated to another person. Interaction implies responsiveness to those with whom one is interacting. When God interacts with people there is movement on God'a part to relate with us and be responsive to us.

The concept of God responding to humanity raises the concern for some that God is capricious and cannot be depended upon. This is not the case. To state that God interacts with people does not mean God is untrustworthy, unreliable, or unfaithful. God remains trustworthy and faithful, because God's nature and concern for people remains consistent even as God interacts with persons. God has often been described by the term "Father" in Christian history. While human parents are by no means perfect, the ideal represented by parents can serve as a model for the trustworthy faithfulness of a responsive God. Ideal parents want their children to grow and mature, and in each stage of their children's development, they require and encourage different things to promote that growth. God's responsiveness to the people that God has created is an outgrowth of God promoting growth and maturity at different stages of development. The responsiveness of God to the condition and concerns of people is a measure of the faithfulness of God towards creation.

Ramifications for Parish Ministry

In this world God has called forth the possibility of life. That possibility carries with it great risks, for it also calls forth the possibilities of suffering. Even though illness and suffering are a part of creation they are not punishment sent from God to persons to punish people. Illness is caused by many factors. Some illnesses strike randomly, carried by air or water; other illnesses are the direct result of actions people take. Examples of this are smoking-related diseases or drinking-related problems. Still other illnesses are hereditary, such as Muscular Distrophy. Yet each illness is affected by heredity. diet, lifestyles, and other factors. Pastors who minister to terminally ill patients need to help these patients sense God's presence and responsiveness to their predicament. Great strength and hope can be gathered from the sense that God is with us in our pain and suffering.

God's power can affect the course of an illness, but that power is the power of love and hope. Much has been written on psychosomatic disorders, physical disorders that are caused primarily by emotional states. It is not uncommon for people under extreme stress to experience more colds than at other times. Certain skin rashes are caused by undue stress, as are heart and stomach ailments. In reality, every

illness is psycho (mental) and somatic (physical).[7] Even though separate descriptions can be given of the psychological and physical aspects, people are complete units, and what effects one part of a person effects the whole. When people begin seriously to accept the forgiving love that God freely extends to all, they find their spiritual and psychological lives so affected that physical changes can happen. It is irresponsible to suggest, however, that if only their faith is strong enough, people can be healed of anything. Life carries with it the possibility of suffering. That suffering cannot be eliminated by faith; yet faith has the possibility of altering its course.

God's power can affect how we respond to an illness. It is often in illness, when people feel they need strength the most, that they turn to God as a source of strength and power. While God continuously seeks to influence the world and the people within it, people always have the option to reject that influence. Responding to the presence of God, and putting faith in the responsiveness of God can bring comfort when no human person can bring comfort.

How people view God also affects their response to a terminal illness. Those who view God as punitive and angry might see a terminal illness as a just punishment for some

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[7] M. Scott Peck, "Alcoholism: A Spiritual Problem", Lecture delivered at conference sponsored by Phoenix General Hospital, 18 Feb. 1987.

great (or little) sin in the past. While they may still accept medical treatment to alleviate symptoms of the illness, they accept their suffering as something that must be undertaken in atonement for their past. What is so often comforting to people who follow this line of thinking, is that they still view God as in control of the world.

Those who do not see God as the mastermind of illness face a dilemma when suffering a terminal illness. In their hurt and sense of loss, they can focus on the powerlessness of God to protect them from pain and suffering, and find such a God useless. Those, however, who focus on God as the author of life, who deemed life precious even with the risk of suffering, can find support and strength in the hope that God is responsive to them and their needs. Even though they suffer, even though they experience moments of depression and loss, they find strength in knowing God is there to strengthen and sustain.

Hope, then, is drawn by patients from belief that God is responsive to people who suffer and that the power of life is finally stronger than the power of death and suffering. A God who loves us, and calls us into being in finite time and space, will continue to love us and continue to call each of us into being when this time and space cease to exist.

Pastors who minister to those who are terminally ill need to keep in mind that patients' ideas concerning God have been formed through years of learning. Even though ter-

minally ill patients have preconcieved notions concerning God, they will still be open to new interpretations concerning God and the presence of suffering. Pastors who believe (1) illness is not punishment from God, (2) God's power can affect the cause of illness, but that power is the power of hope and love, (3) God's power can affect how we respond to illness, (4) how people view God affects their response to terminal illness, 5) God is responsive to people who suffer, and (6) the power of life is finally stronger than the power of death and suffering, will find they have much to offer to terminally ill patients. Such pastors will be compassionate, caring, and hopeful as they journey with their parishoners down one of the hardest roads of life.

CHAPTER 3

Elisabeth Kuebler-Ross

History

Dr. Elisabeth Kuebler-Ross is the foremost author to bring to general attention the issues and concerns of the terminally ill and their families. Dr. Kuebler-Ross traces her interest in death and the dying person to her experiences in post-war Europe. She speaks about the chilling effects the sights and smells of Europe had on her

> Whoever has seen the horrifying appearance of the concentration camps, has smelled the smell of burned bodies of millions of innocent victimes, and has set his eyes on carloads of children's shoes collected from the murdered little ones may be preoccupied with death for the ensuing years.[1]

Death, however, was not just a past happening to be remembered. As Kuebler-Ross worked amidst the sights and smells she described, she also worked among the people of post-war Europe. It was among these that she gained a profound respect for those who faced death. She writes movingly how, not far from where she lived, she could see a family sitting around the bed of a dying mother.

> . . . a kerosene lamp burning, one of the children reheating a cherry-stone bag to keep the mother

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[1] Elisabeth Kuebler-Ross, "The Dying Patient as Teacher: An Experiment in Experience," Chicago Theological Register 57, no. 3 (Dec. 1966): 2.

> warm, and grandmother holding her daughter's hand silently until she passed away. It was a silent sharing of the inevitable.[2]

This experience caused her to reflect seriously on this family and the way they dealt with death in their midst. Questions filled her head. Why did they seem unmoved? Had this family's past experiences with death dulled their senses to suffering? Why were the children allowed to be present, even to participate at this moment of death. Didn't the family feel the final separation from their loved one? Reflections on her questions brought her an answer:

> I have seen those who still had the feeling of togetherness to the end, for whom death was an accepted part of life that was not hidden from youngsters. They learned to face death as an intrinsic part of life. Since nobody tried to hide it from the children, it became part of their lives . . . Life continued much as it always had been, except perhaps for some added attention and little tokens of love toward the dying.[3]

It was nearly twenty years after her experiences in post-war Europe, that Kuebler-Ross found herself once again reflecting on the needs and attitudes of the dying person. She was employed in the Department of Psychiatry at the University of Chicago Billings Hospital. There, in 1965, four theology students decided to do a research project on a crisis in human life. These students considered death to be the greatest crisis a person had to face, and they came to Kuebler-Ross seeking her assistance with their project:

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[2] Ibid.

[3] Ibid., 2-3.

> Then the natural question arose: How do you do research in dying, when data is so impossible to get? When you cannot verify your data and cannot set up experiments? We met for a while and decided that the best possible way we could study death and dying was by asking terminally ill patients to be our teachers.[4]

Having decided on a method of research, Kuebler-Ross and her students believed the hardest part of their work was finished. True, they needed patients to interview, but since Kuebler-Ross was quite comfortable with the idea of interviewing dying patients, she did not envision any difficulties getting referrals from the hospital staff. Reality, however, proved to be different. Doctors were horrified that anyone would want to talk to patients about their death. "There were suddenly no dying patients in a big general hospital."[5] If they were dying they were much too sick to be interviewed.

While doctors appeared to be unanimously against the project, the attitude of the nursing staff was more divided. Many nurses were enthusiastic about the project. Some of these nurses had become angry with doctors for not being more open with their patients. Still others were frustrated because they had more contact with the complaints and needs of the family than did the doctors who just came in on rounds. Other nurses were openly hostile. One nurse asked Kuebler-

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[4] Elisabeth Kuebler-Ross, On Death and Dying (New York: Macmillan, 1969), 21-22.

[5] Kuebler-Ross, "The Dying Patient as Teacher", 6.

Ross if she "enjoyed telling a twenty-year-old man that he had only a couple of weeks to live!"[6]

The reactions of other hospital staff, such as orderlies, nurses' aides, and other less educated people differed greatly from the rest of the medical staff. They cooperated with and encouraged Kuebler-Ross to continue with her efforts to interview patients. The less educated staff seemed to have the least anxieties about dying persons discussing their situation:

> We can say, however, that in the staff, too, the same attitudes prevailed. There were clear cultural differences. The more advanced, educated, and sophisticated, the more resistance we felt for this project and the more massive was the defensiveness.[7]

The patients, however, almost unanimously accepted the project when Kuebler-Ross spoke to them about it. They were anxious to share their feelings, their anger, pain, and loneliness. Many patients were surprised that anyone wanted to talk with them. The only two patients who were not interested in being interviewed were unmarried, isolated people who always felt they had nothing to contribute to others.

The first interview taught the group perhaps its hardest lesson--the urgency with which some people need to talk:

> When we finally had a patient, he welcomed me with open arms. He invited me to sit down and it was

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[6] Kuebler-Ross, On Death and Dying, 23.

[7] Kuebler Ross, "The Dying Patient as Teacher," 7.

> obvious that he was eager to speak. I told him that I did not wish to hear him now but would return the next day with my students. It was so hard to get one patient, I had to share him with my students. Little did I realize then that when such a patient says "Please sit down now" tomorrow may be too late. When we revisited the next day, he was lying back in his pillow, too weak to speak. He made a meager attempt to lift his arms and whispered, "Thank you for trying." He died less than an hour later . . . . It was our first and most painful lesson.[8]

Interviews became a common happening in the University of Chicago Billings Hospital. The class size went from four interested seminary students to fifty. The interviews no longer were done in the patients room, instead, the interviews took place in a specially equipped room with a one way mirror on one wall. From an adjoining lecture hall, the audience could see and hear what was going on in the interviewing room.

After the interview was over, the patients were returned to their rooms. Then the interviewers joined the audience for discussion. Patients' responses to different questions were discussed. Finally, the class attempted "a psychodynamic understanding of his [the patient's] communication."[9]

The reactions of students have been varied across the years. Some hoped to side-step the interviews, citing previous experience with the dying as fulfilling that requirement. Others entered the class, and then came face to face

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[8] Kuebler-Ross, On Death and Dying, 23-24.

[9] Ibid., 26.

with their own fears. A typical response comes from excerpts from a letter of one of Kuebler-Ross' students.

> I joined the group that went to Billing Hospital to see Dr. R. because I wanted to gather material for a paper I was writing on the subject of death. I wanted a "quick" paper, but I found that a mere paper could not satisfy the requirements that necessity established. The problem was not to write about death, but to meet it . . . I had been well satisfied that I did not fear death. I was not afraid to die - I didn't like the idea, but I accepted it. I did not like the idea that those close to me would have to die, but I accepted that too. But the idea of meeting someone who was going to die, who knew, and who was waiting for it to happen - that terrified me. It was almost as if those people were of a different species that I. Sentence had been passed on them, they knew something that I did not, they were lying in a world of expectation different from my own, and they were (I am sure) not willing to talk to me, much less listen to me.[10]

Upon leaving the University of Chicago, Kuebler-Ross became involved in the lecture circuit, being a guest at seminars, talk shows, lecturing at nursing schools, and other organizations. Even though she felt able to communicate the ideas she had developed concerning care of patients, she still was not totally satisfied with the work she was doing. After ten years of only describing the problem, she had an idea.

> It was in 1970 that the thought occurred to me that I was ready to choose a relatively small group of people to work with in more depth. I would spend a whole week with them in a live-in retreat and experiment with the desire to share with them more than just verbal communications. I wanted to have more time with them and allow them to experience what it is like when our own negativity,

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[10] Kuebler-Ross, "The Dying Patient as Teacher," 5-6.

> our own fears and unfinished business, interferes with our effectiveness.[11]

The workshops have, from the beginning, been a great success. They have brought together people from various walks of life, who either were terminally ill, had been effected by the illness of someone else, or who were professionals (medical, therapeutic, and religious) who worked with the ill.

By 1976 Kuebler-Ross became aware that the task she had undertaken, of traveling around the country doing workshops, was a job she could no longer handle. In 1977 she was able to purchase 42 acres of hilltop property, which she named Shanti Nilayas, which is Sanskrit for Home of Peace. Kuebler-Ross uses Shanti Nilayas as ". . . our administrative center and (a place) to train the staff for future Shanti Nilayas across the country and abroad."[12] Kuebler-Ross continues to lead workshops around the country.

The most famous part of Kuebler-Ross' work is her five stages of grief, learned by watching the dying patients. These five steps are denial and isolation, anger, bargaining, depression, and acceptance.[13] Careful watching of the dying patient taught Kuebler-Ross that these stages are not hard

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[11] Elisabeth Kuebler-Ross, Working It Through (New York: Macmillan, 1982), 11.

[12] Ibid., 26.

[13] Kuebler-Ross, On Death and Dying, Chapters 3, 4, 5, 6, and 7. Each deals with a stage of dying.

and fast linear stages, progressed through by each patient in a neat and orderly fashion. Sometimes a patient gets stuck in one of the stages. Sometimes he/she regresses to an earlier stage. Rarely, one stage is passed through so quickly, that it seems not to have been passed through at all.

Basic Principles

The motivating spark behind Kuebler-Ross' work is her concern for the dying individual as a human being. She was on the forefront of a movement that criticized society for letting dying become lonely and impersonal. Basic to her work are the principles: (1) We can learn what the dying patient needs from the dying patient; (2) Community is important for the dying person so they are not alone; and (3) Good is gained for persons who, in working with dying people, learn and deal with their own death.

The first principle is highlighted by Kuebler-Ross when she begins the final chapter of On Death and Dying. She states:

> From the foregoing it is evident that the terminally ill patient has very special needs which can be fulfilled if we take time to sit and listen and find out what they are.[14]

Kuebler-Ross structured her whole method of research upon this assumption. She did not read books about dying, or ask a theology, psychology, or philosophy class to come up with the answers. Instead, she structured her work in Chicago so

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[14] Ibid., 268.

that she would be able to ask the dying patients themselves what their needs were. Each patient was recruited in the same way.

> He was told in a matter-of-fact way that we were interested in "very sick and terminally ill patients" in terms of their feelings, wishes and thoughts during their lonely hours in the hospital.[15]

After each interview, the audience discussed the patient, and then made suggestions that might make their dying easier.

After Kuebler-Ross had left Billings Hospital in Chicago, she still emphasized listening to the needs of the patient. Writing about the work she and others on her staff have accomplished, Kuebler-Ross states:

> Our work has included a total care of every need the dying may have. We have allowed them to be in control of the time and place of this care, of the amount of pain medication they require to allow them to remain conscious and alert, yet pain-free. We have respected their wishes to leave a hospital when there was no more active treatment available.[16]

In the very act of sitting down and listening to the patients, she found that community, and the chance to share, are important for the dying person. This, her second principle, has caused Kuebler-Ross to deplore the fact that dying has become no longer a very personal, intimate and family affair. Instead, it becomes a time of isolation with patients

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[15] Kuebler-Ross, "The Dying Patient as Teacher", 4.

[16] Elisabeth Kuebler-Ross, Living With Death and Dying (New York: Macmillan, 1982), 4.

hooked into machines, sedated so they can't communicate and share. Patients were eager to participate in Kuebler-Ross' seminars, glad of a place to share their feelings and needs. Mostly, they gain a sense that they are not alone just because they are dying. "The most frightening thing about dying for most people is the feeling of being alone."[17] Participation with other people reduces that sense of being alone.

Providing community and a chance to share does two more things for patients. It fulfills their need to talk about death, and it helps them die. Those who participated in the Kuebler-Ross seminars found the needed opportunity to talk about death.

> (The) almost uniform acceptance on the part of our patients (to being interviewed) may be explained in various ways. The most important is the fact that most dying patients wish to talk about death. They welcome a break-through of their defenses. They welcome a frank, unemotional, honest discussion and a sharing of their feelings.[18]

This need to talk is magnified by the fact that there are so few people willing to listen to the feelings of the dying person.

Talking, and the feeling of community, also helps the patient to die. Time and time again in her case studies, Kuebler-Ross tells how the interview let people "get-out"

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[17] Elisabeth Kuebler-Ross, ed., Death: The Final Stage of Growth (Englewood Cliffs, NJ: Prentice Hall, 1975), 27.

[18] Kuebler-Ross, "The Dying Patient as Teacher," 8.

their hurt and frustrations. Then, after the frustrations were out, persons were able to make their arrangements, complete their lives, and die peacefully. One old Lithuanian woman was panicky when she thought about dying:

> She was finally able to express a very specific fear of hers, namely, the horrible aspect of "being eaten up by the worms." Her middle-aged daughter, standing next to her bed answered, "If that's what keeps you from dying, we can burn you." (A more literal translation of cremation.) The old woman did not need words to communicate her reaction. A second interview with both women alone resulted in much needed clarification, and both of them spent a relaxed hour together - "The best we ever had together" - before the old woman died.[19]

For many terminally ill patients, community is associated with a place, and that place is home. As death draws near, and the illness enters its final stages, many people become uncomfortable with the hospital environment. Not wanting to die alone in a hospital, surrounded by machines, many patients express the desire to be at home, in familiar surroundings, and with the people they love nearby. Kuebler-Ross wholeheartedly supports this, stating, ". . . I am a strong believer that patients should be allowed to die at home . . . ."[20]

Kuebler-Ross' third principle is that reaching out to a dying person as if they were human helps not only the patient, but it also helps the person who does the reaching

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[19] Ibid.

[20] Elisabeth Kuebler-Ross, Questions and Answers on Death and Dying (New York: Macmillan, 1974), 88.

out. This is because dealing with those who are dying causes one to face the crises of one's own death. Time and time again, those who worked with the dying patients told about their initial fears and anxieties.

> And then, after a while, I understood that there was no wall that separated us; he was not a different species than I, because I had to face my own death too. We were the same, because we were both mortal . . . I was afraid that might be me there.[21]

Yet, even with a person's fear of death, Kuebler-Ross feels there is one inescapable fact. Death will soon come to us all sooner or later. Those who have not reconciled themselves to the inevitable pay for it.

> It is the denial of death that is partially responsible for people living empty, purposeless lives; for when you live as if you'll live forever, it becomes too easy to postpone the things you know that you must do. You live your life in preparation for tomorrow or in remembrance of yesterday, and meanwhile, each today is lost.[22]

Those who have accepted the inevitable learn and grow from their experiences. "For those who seek to understand it, death is a highly creative force. The highest spiritual values of life originate from the thought and study of death."[23] Poetry, art, literature, philosophy, all have seen some of their finest works as a person contemplates death.

When you finally understand that each day you

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[21] Kuebler-Ross, "The Dying Patient as Teacher", 6.

[22] Kuebler-Ross, ed., Death: The Final Stage of Growth, 164.

[23] Ibid., 1.

> awaken could be the last you have, you take the time that day to grow, to become more of who you really are, to reach out to other human beings.[24]

Kuebler-Ross sees coming to terms with one's death as having more than a personal impact. If people truly accept death, the impact will be social, including your own localities, the nation, even the entire world; ". . . we may achieve peace--our own inner peace as well as peace between nations--by facing and accepting the reality of our own death."[25]

Evaluation and Application of Principles

Learn From A Dying Person

God, who is responsive to the human predicament, wishes for each person maturity and spiritual growth. Just as God is responsive to people and their needs, so parish ministers are called to be responsive to the individuals within their scope of ministry. Kuebler-Ross' first principle, we can learn what the dying patient needs from the dying patient, reflects well the theological concern that God is responsive to people in their present circumstances.

Just as God is responsive to people in their present circumstances, so must parish ministers be responsive to the needs of terminally ill persons within their parish. Pastors are confessors when people have a burden of guilt that needs

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[24] Ibid., 164.

[25] Kuebler-Ross, On Death and Dying, 18.

to be relieved. Pastors are teachers, bringing new biblical and doctrinal information to those who are searching for answers, or needing instruction. Pastors are counselors, reconciling individuals to themselves, to God, and to others. Ministry is many things, yet central to ministry is the idea of pastors as God's representative to the people within their sphere of influence, and to the world.

The difficulty lies in determining the needs of the patient. It made sense for Kuebler-Ross to approach those hospitalized with the following format. She would enter the room, introduce herself, and explain that she and some students were studying the needs of the dying patient. She then would ask if the patient wanted to talk. Most often the patient did talk, and the students learned a great deal about the patient's needs.[26]

Pastors cannot use such an approach. Pastors can, however, come up with original questions that can bring specific issues to the forefront. As representatives of congregations, pastors may ask, "Is there anything anyone from the congregation can be doing?" As healers of broken relationships, pastors may ask about feelings about individual family members. As representatives of God, pastors may ask personal, theological questions.

Often, the issues pastors will deal with will be set by

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[26] Kuebler-Ross, On Death and Dying, 24.

the stage of grief the patient is in. These stages, defined by Kuebler-Ross, are denial, anger, bargaining, depression, and acceptance.[27]

The Christian faith has always paid lip service to the idea that the truth will set people free. When patients are diagnosed as having a terminal illness, their denial is the first step in the lengthy process of accepting the truth about their physical condition. It can be the privilege of pastors to help patients begin to hear the truth, and accept its consequences for their lives.

As patients move into the stage of anger, the pastor can become reconciler. Often patients are angry at themselves, angry at their bodies for betraying them with this disease, angry at some past indiscretion or bad habit, such as smoking, that could be a direct cause of their illness. Sometimes the anger is projected at others, those who cause illness by spraying pesticides, or polluting the environment with carcinogens. Here, the reconciling pastor can help patients discover forgiveness for themselves and others.

Many patients express anger against God. After all, God is the one who could have prevented the illness, with a single wave of the hand. It is difficult not to think of serious illness in the light of punishment and reward, especially when the illness is personal. The patients repeat

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[27] Ibid., 38f, 50f, 82f, 85f, 112f.

over and over, for themselves and for others to hear, "Why me? There are so many people in the world who are evil, who care for no one else but themselves, and yet they seem to live happy, prosperous lives. Why should I suffer this disease?"

The concept of illness and health as punishment and reward can quickly move the patient into bargaining. When bargains are presented to God, and perceived as rejected, the patient can cycle back into anger. When a patients promise God to attend church regularly, if God will heal them, they then experience rejection if no healing occurs.

Seeing no hope or help in bargaining with God, the patient often slips into a depression. It is a moment of re-examination of self, of worth within the world, of relationship to God, family, friends, and church. It may be a time of mental dis-orientation, without being a time of mental disease. The patients may be extremely uncomfortable with themselves, and with their thoughts, but caring support can help them come to a new understanding of themselves and others.

Ruth is an older woman who has had a slow-growing inoperable cancer.[28] The evidences of the cancer's slow growth are there constantly. Intermittent hemorrhaging and pain remind her of the steady unwanted invasion of her body.

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[28]Names and identifying data have been changed.

Chemotherapy, which makes her very ill, at first slowed the growth of her tumor, but recently has had no effect. Since her symptoms come and go, she cycles between denial, anger, and bargaining. At times when the symptoms are minimal, she expresses the hope that doctors accidently mixed her chart up with someone elses. She is certain there is no tumor, and that it may never have existed. When the symptoms are in full force, she alternates between being angry with God for reneging on their past agreement (I'll be good, if you take away the disease), and trying to strike a new bargain with God.

Ruth's needs from her pastor are extremely complex. Ruth consistently presents theological questions, but refuses to deal with them in any way that disturbs her cycle of denial to anger to bargaining and back to denial. She asks the basic question, "Why am I the individual who suffers?" But because she always returns to the idea of illness as punishment, she searches for the great and terrible sin she committed.

Ruth carries a heavy load of inappropriate guilt. The pastor here walks a fine line, trying to accomplish two things. First, the pastor speaks God's loving word of forgiveness to all who seek it. Second, to try to prevent the guilt from returning, the pastor attempts to help Ruth develop a different outlook on illness, one that does not deal in reward and punishment.

The main difficulty with pastors fitting their actions to meet the needs of others is that it calls for creativity. Openness is required of pastors who seek to determine the level of spiritual maturity for individuals. A sense, even, of audacity is required so pastors can view themselves as being able to help others move towards spiritual maturity. The saving grace for pastors in this situation is humility. Such humility reminds pastors they too walk the road of increasing spiritual maturity and they need guidance and direction from God and from those around them.

Importance of Community

God's responsiveness to the human predicament is not limited to desiring spiritual maturity for individuals. Instead, God's responsiveness finds form and shape in the love of God that seeks to influence people. Christian Community takes seriously the message Christ proclaimed: that the Kingdom of God, the very presence of God, is with us in and through all things.

Kuebler-Ross' second principle, that community is important to dying persons so that they are not alone, is the sociological statement of an issue that is also theological. There is a need for human beings to be in community that enables them to reach out to God, and to sense God reaching out to them. The Church and its pastors need to take very seriously its mandate to comfort the afflicted and to be with people in their suffering just as God is with people in their

suffering.

The early Christians' sense of Community helped them face the persecutions of a suspicious world. Believing that wherever "Two or three are gathered as my [Jesus] followers, I am there among them."[29] The early Christians sought times and places to gather together. They looked for ways to serve each other, with the collection of funds for congregations in areas where there was famine, with ministry to orphaned children, and with the feeding and caring for those within their own communities who were hungry and needy.[30]

The Church continues that extension of community to those within fellowship, and seeks to extend that community to those who wish to become participants. Dying persons are still persons, and they need to maintain as far as possible relationships with their religious communities.

John had not been a particularly religious man during his young and middle years.[31] Upon retirement, John and his wife would travel to Arizona during the winters to escape the harsh snows of the northern states. It was during one of these winters that he and his wife became involved in a local congregation. A few years later, also in winter, he was diagnosed as having terminal cancer, with only a few months

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[29] Matthew 18:19 (RSV).

[30] References to such offerings are found in the New Testament, i.e., Acts 2:27-30; 1 Cor. 16:1-4; 2 Cor. 8:1-4.

[31] Names and identifying data have been changed.

left to live. The illness progressed too rapidly and debilitatingly to even consider returning home during that winter. Concerned friends made regular calls on John and his wife during the early weeks of his illness, but his cancer progressed rapidly, and John quickly weakened. Soon, he was too weak at home to have many visitors, and during his periods of hospitalization, hospital rules allowed only family and clergy to visit. John had quickly passed through the stages of grief, and was accepting of his illness, his limitations, and his impending death.

It was during these last few weeks of life that regular visits from the pastor took on a special meaning for John. When friends from the congregation could no longer visit, the pastor always could. Often, there would be little conversation, a brief exchange of hello's, the pastor bringing greetings from different people in the church, minutes of quietness shared together, and a parting prayer. It was through the regular visits of the pastor that John felt the love and concern of his church friends when they were no longer allowed to come and express it themselves. The pastor's visit not only meant that the pastor cared, but it also meant that John's church cared. That even though he was ill, at home, or in the hospital, he was still a part of the worshipping community of faith.

Working with Terminally Ill Benefits Those who Work with Them

Kuebler-Ross' final assumption is that working with the terminally ill not only benefits the ill person, but it benefits those who work with them. The basic benefit received by those who work with the terminally ill is a coming to terms with their own death. While this may be true in principle, is coming to terms with one's own death important in a theological sense?

Part of spiritual maturation is to begin to deal with life realistically and in it's totality. Dealing with one's own life includes dealing with one's own impending death. As God calls people to grow spiritually, so God calls people to take the risk of coming to terms with their mortality.

Coming to terms with one's own death allows one to confess an awareness of the presence of God, and it also allows one to place faith in the promises of Christ. One of these promises is that death is not an end, but a beginning. Death also reminds us what a precious gift life is. John Claypool, in his first sermon following the loss of his thirteen year old daughter to

> Here, in a nutshell, is what it means to understand something as a gift and to handle it with gratitude, a perspective biblical religion puts around all of life. And I am here to testify that this is the only way down from the Mountain of Loss. I do not mean to say that such a perspective makes things easy, for it does not. But at least it makes things bearable when I remember that Laura Lue was a gift, pure and simple, something I neither earned nor deserved nor had a right to. And when I remember that the appropriate response

> to a gift, even when it is taken away, is gratitude, then I am better able to try and thank God that I was ever given her in the first place.[32]

Coming to terms with the crucible of death, for oneself, is not an easy task. It does not happen to individuals automatically with the onset of puberty, or at the golden age of 65. If one attains a comfortableness about the possibility of one's death, it comes only from having dealt vigorously with that issue.

Anne spoke to her pastor concerning the first time cancer was diagnosed for her.[33] While in the doctor's office, the doctor gave his diagnoses and discussed with Anne treatments and the possibilities for her future. The doctor then concluded the visit by saying, "I know you are a Christian with a strong faith. For that reason, you should have no trouble accepting your illness, for death should not frighten you." Anne paused for a moment, and reflected in her face was the pain those words still brought. Then, slowly, carefully, Anne went on, "But its only words. When you stand, for the first time, at the open door of death, it's only words. All individuals have to work it through for themselves."

Tillich describes the possibility of non-being (death) as threatening the very core of an individual's meaning.[34]

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[32]John Claypool, Tracks of a Fellow Struggler (Waco: Word Books, 1974), 82.

[33]Names and identifying date have been changed.

[34]Paul Tillich, The Courage to Be (New Haven: Yale Univ. Press, 1952), 41.

Tillich proclaims that it takes courage to come face to face with the possibility of the end of one's being. Those who successfully deal with the threat of death, emerge victorious, strengthened in faith and hope.

CHAPTER 4

The Hospice Movement

History

> Hospice: a program which provides palliative and supportive care for terminally-ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency . . . Originally a medieval name for a way station for pilgrims and travelers where they could be replenished, refreshed, and cared for; used here for an organized program of care for people going through life's last station.[1]

The Hospice movement, as it is known today, had its beginnings in Ireland. In the nineteenth century a Catholic Order, the Sisters of Charity, began reaching out to the dying poor of Dublin. Here they ofen found the terminally ill people living alone in tiny one-room apartments, where they would die alone. If they were not alone, they were packed into rural homes, sometimes with a dozen persons living in a two-room hut, where those employed to take care of them had neither the energy or skills to care for them. These Irish nuns provided for the dying clean places and loving care. Their work expanded, and the Sisters of Charity provided this care in other parts of Ireland, then England,

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[1]Parker Rossman, Hospice (New York: Association Press, 1977), 240.

Asia, Africa, and Australia.[2]

In recent decades, funds from national health insurance in England, and from other agencies have enabled the Hospice movement in England to expand. These hospices of England, which in 1977 numbered over 25, are able to provide the terminally ill with an environment different from that of a conventional hospital.[3]

Dr. Cicely Saunders was the driving energy begind the planning and building of St. Christopher's Hospice in England. It is the vision of Dr. Saunders that makes St. Christopher's Hospice one of the most famous in England. The building of St. Christopher's, however, was not a simple task.

> (Dr. Saunders) took up social work when a problem ended her career as a nurse, and then became a physician because she wanted to find a way to ease the pain and distress experienced by people in the final months of life. The first monetary gift towards her imagined hospice program came from a dying Jewish man who gave her $1,000 and said, "I want to be the first window in your hospice."[4]

The way the building looks, and how it is run is very important to those who have created the English hospices. They have tried very hard to make each hospice a "place" instead of an institution. Patients are not hidden from the world, but made a very active part of it. St. Joseph's

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[2] Ibid., 83.

[3] Ibid., 84.

[4] Ewens and Herrington, eds., 11.

Hospice, in the center of London, has large glass windows from which patients can look out to see a beautiful garden. Patients are free to roam there, and neighborhood children are encouraged to come there to play, so that patients might be cheered by the happy noise the children make. Across the garden is a very busy street, where patients are able to watch the hustle of everyday life. "The staff found that to put a patient in a window bed was one of the best cures for depression."[5] So the hopsices of England seek to create a setting for the terminally ill that encourages living.

At St. Christopher's normal activity is stressed, and opportunities for involvement in various activities are supplied. Even with the opportunity for involvement in normal activities,

> The privacy of each individual is respected. Those patients who do not wish to join the activities are left to themselves.[6]

Yet, even with all this innovation in setting, the hospice would be just another hospital if it were not for the attitudes of the staff. The hospice system is patient-oriented. Nurses feel free to sit and talk with patients, children and babies are allowed to visit at any time, and routines are unhurried so that there is plenty of time for personal concern. All in all, the patients find their per-

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[5] Rossman, 85.

[6] Paul M. DuBois, The Hospice Way of Death (New York: Human Sciences Press, 1980), 74.

sonhood respected, and attention given to their needs.

> Even the scrubwoman, the cook, and the hairdresser view themselves as part of the "caring team," alongside the occupational therapist, the chaplain, the social worker, and the volunteers. Most of the patients, too, were caught up in the team spirit, seeking to minister to each others needs and concerns.[7]

The English hospice catches first-time visitors off-guard. Many people expect a gloomy atmosphere, and patients in their last throes of life. Instead, the Hospice is cheerful, alive, human. LoYi Chan had been asked to be the architect for a hospice in America. He came to St. Christopher's Hospice in England to get ideas for his design.

> As he packed in December in 1975 for his two week trip to London, (he) reported his puzzlement over whether or not to take his favorite red tie. In Canton, China, where he was born, red meant happiness and the color was never worn at funerals. He feared that the tie might not be appropriate at a hospice for the dying, but finally he packed it . . . As with many other first time visitors to a hospice they (LoYi Chan & his wife) hardly knew what to expect . . . But LoYi Chan said: "I don't know why I was worried about the tie. It was so cheerful there."[8]

One of the primary intents of the hospice program is to relieve pain. Of patients suffering from cancer, "40 percent (suffer) with moderate to severe pain."[9] One of the first goals of the staff is to control the pain so that a quality

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[7] Rossman, 88.

[8] Ibid., 86-87.

[9] Sylvia Lack, "Pain Control in Terminal Illness." A Hospice Handbook, eds. Michael Hamilton and Helen Reid. (Grand Rapids: Eerdmans, 1980), 75.

of life can be restored. This is different from hospitals, where the primary intent is cure. Often hospital staffs are reluctant to increase drug dosages for fear of addiction to a narcotic drug. Sometimes the staffs are afraid that the drug might slow down the healing process. Hospice staffs assume that once people are definitely dying, then the comfort of patients takes precedence, whether or not they become addicted to the drug.

> Effective pain control is based upon a tripod of treatment supporting the primary goal: a pain-free patient with normal affect. Mental acuity need not be sacrificed to the cause of freedom from pain; pain need not be the price paid for awareness.[10]

While pursuing this goal of pain relief, hospice staffs have discovered that there are different sorts of pain. There is the pain that is physical, caused by the disease. There is also the psychological pain, the anticipatory pain, that comes from knowing that one will be in pain again. One of the goals of hospice medication is to keep the patient free enough of physical pain, that the pain of anticipation and dread begins to disappear. As for the question of addiction: "The advantages of a comfortable and dignified life for the terminally-ill patient far outweigh any possibility of long-range addiction."[11]

Although all the examples of hospice care mentioned

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[10] Ibid., 75.

[11] Rossman, 92.

above are unique palliative-care facilities, this is not the only model for hospice care. As quoted before, from the official definition of hospice, a hospice is "a program which provides palliative and supportive care for terminally-ill patients and their families."[12] It is possible to have a special hospice wing for a hospital, like St. Luke's in New York, or the Royal Victoria in Montreal. Other alternatives include special care in nursing homes, care for patients who remain at home, and day-care alternatives combining home and in-patient facility. There is the possibility of more alternatives as one's mind is put to it.[13]

Basic Principles

Although hospices take many forms, from being a separate institution with its own building, to being a program to help patients at home, all hospice treatment has the same set of basic principles. Hospice treatment is based on the assumption that once a patient hears the word, "nothing more can be done for you", something can and should be done. In other words, there is never any reason for not reaching out and meeting the needs of persons, regardless of whether they will live past the moment. Some things that can be done include strengthening the individual diet and treating physical discomforts. Even new friends and interests can be provided to

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[12] Ibid., 240.

[13] Ibid., 128-129.

help the patient through to death. In addition to accepting the fact that something still can be done for anyone, three principles guide hospice care: (1) Patients and their families are the units of care; (2) Team work among professionals is mandatory; and (3) Comfort not cure of patients is the goal.

The first principle that guides hospice programs is to see patients and their families as the units of care.

> The family together with the patient is the unit of care. Care directed toward the patient must include concern for other persons in his life who are important to him.[14]

Patients and their families are not expected to adjust to a hospital like routine. In hospices there generally are no visiting hours. Family members are free to come and visit whenever it is convenient for them. There are no age restrictions for visitors, children are welcome in hospices at any time.

It is the goal of the hospice treatment to keep family members together during one of the most difficult stages of life. Family members are expected to participate in the lives of the patients in whatever way is truly beneficial to the patient and the family structure.

Often, concern is raised about the presence of children among those who are so obviously dying. While children

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[14] Theodore Koff, Hospice: A Caring Community (Cambridge: Winthrop, 1980), 33.

should not be forced into a situation in which they are uncomfortable, "there is a unique relationship between children and the terminally ill that certainly must border on the spiritual."[15] Time and time again the literature concerning hospices gives examples concerning the benefits of allowing children to visit with the terminally ill. There are benefits both to the ill person, who maintains important relationships until the time of death, and to the children, who learn early to accept death.

The extension of hospice care to include the family members is based on two criteria. One is that the family members really do need care and concern during the time of terminal illness of a loved one. They go through the same stages of grief as mentioned before in the chapter concerning Kuebler-Ross. These family members have needs of their own that should be met.

The other criterion concerns the terminally ill patients. Seeing the family as unit of care is really also caring for patients. Patients' needs are met because their families are better equipped to deal with the pressures of having a terminally ill member. As the hospice system treats patients and families, it takes into account the importance of community, social life, and personal relationships.

The hospice design seeks not only to foster the com-

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[15] Ibid., 34.

munity life of the patients, but also the family members. In communities where the hospice care consists of in-home care much of the hospice program revolves around providing respite for the family. On a regular basis members of the hospice team come to the homes and provide care for the patients so the family members can have some relief. Counseling and grief support groups are available to family members following the death of the patient. Many hospices offer support programs for the families for at least 12 months following the death of the patient.

Every effort is made during patients lives as well as at their death to maintain the community that is important to them. At St. Christopher's Hospice care is taken so that patients are not alone at the moment of death. Curtains are not closed, people are not shushed, visitors and family members are not taken from the room. Everything is done so that "no person felt alone or abandoned at the moment of death."[16]

The second principle fundamental to the hospice system is that teamwork among professionals is mandatory. Such a spirit of teamwork allows for the smooth functioning of the hospice system.

> The staff of a hospice is a multidisciplinary team that makes up a caring, competent, and therapeutic community . . . its members should include nurses, social workers, physical and occupational therapists, chaplain, clinical pharmacologist, activity workers and case manager. Volunteers comprise an integral part of the team of caregivers.[17]

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[16] Rossman, 88.

[17] Koff, 116.

To facilitate team work, regular meetings are held with the members of the team discussing individual patients in depth. Every member of the team needs to know what is happening with the patients. This team concept not only provides support for patients and their families, it also provides support for the members of the team who are continuously working in the hospice. When the team works together, it is able to support and strengthen itself.

The third principle of hospice care assumes that comfort, not cure, of patients is the goal of the program. Once it has been determined that there is no possibility of cure, the most important thing a hospice can provide is comfort. St. Christopher's Hospice led the way in developing adequate means of pain control.

> The first goal of St. Christopher's is to make the patient free of pain, and of the memory and fear of pain, by arranging that continuous dosages of analgesics be given so the patient is always one step ahead of the pain.[18]

Brompton's mixture, consisting of alcohol, fruit syrup, cocaine, heroin, and chloroform water is used by some hospices to prevent the pain so often associated with terminal illnesses. Instead of giving the pain dosage after the

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[18]Constance Holden, "Hospices for the Dying, Relief from Pain and Fear," A Hospice Handbook: A New Way to Care for the Dying, eds. Michael Hamilton and Helen Reid. (Grand Rapids: Eerdmans, 1980), 58.

pain has already started, the hospice team tries to find that point where the patient is without pain, yet not sedated. Once the amount of medication is determined, it is given on a regular schedule to keep the patient pain-free.

In some areas, doctors have been reluctant to discover the necessary medication needed to prevent pain. This is due to doctors concerns that the narcotics needed to prevent the pain may have negative side effects, or may, in fact, be addictive to the patient. Dr. Sauders, founder of St. Christopher's, believes "such considerations are irrelevent to the dying."[19]

Evaluation and Application of Principles

Patient and Family Unit of Care

The very nature of God is love. This love is a love that extends to every individual, every person who ever lived. That love reaches out regardless of age, physical condition, theology, or past actions. God reaches out to the terminally ill, to live with them, to give them hope and courage to face their life and even their death. God reaches out to the families and friends of the terminally ill. God seeks to bring into their lives comfort and hope, hope not only born of the chance for a cure, but hope that somehow, even after death, love is still the strongest force around.

Pastors who seek to live as God's agents within the

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[19] Ibid., 59.

world reach out in love to all who come within their sphere of influence. The Hospice Movement's principle that patients and their families are the units of care can remind parish ministers that the pain and suffering of a terminal illness extends beyond the individual who is sick. As pastors extend their field of care to include the families of patients, they are extending their field of care to include the most important community available to patients. By discovering the needs and concerns of patients' families, pastors encourage healthy support systems for the patients.

The opportunities for congregations and pastors to provide care and concern for families of patients are varied. Quite often, family members of patients are involved in the same religious community as the patients are. When family units are a part of the religious community, pastors have an opportunity to minister to the family during the time of illness and in their bereavement.

Ben and Sarah are a middle aged couple with one teenage daughter.[20] For years Ben and Sarah have flirted with church membership, making promises to attend, yet never quite making it to church. The pastor was called to the hospital when it was discovered the daughter, Alice, had an inoperable brain tumor. The family had prepared for a long illness when, in the hospital, Alice suffered a cerebral hemorrhage. The

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[20]Name and identifying data have been changed.

swelling of the brain from the hemorrhage, and the pressure from the growing tumor caused permanent brain damage. Immediately placed on life support systems, it took four long days for the doctors to determine Alice was probably brain dead, to clean her system of pain killers and sedatives, to perform the final tests to determine there was no life left, and to counsel Ben and Sarah concerning the possibilities of removing life support.

Ben and Sarah agonized those four days over their "failures" as parents. High on their list of failures was their concern that they had not become active in the church where they were members. Perhaps God was punishing them for this laxness. It was the presence of their pastor, who helped Ben and Sarah not to see God as an adversary, punishing them by inflicting Alice. Instead, the pastor helped Ben and Sarah to seek strength in the presence of God, even in the midst of suffering. Ministry continued when, at the funeral, the pastor shared the mystery of life, and shared the hope of Life Eternal. In time, Ben and Sarah were able not to blame God for the death of their daughter, but instead to rely on God to help them deal with their pain and loss.

Pastors also find opportunities to minister to families who have terminally ill members, but who live quite a distance from the patients. The congregation has a chance to support the family members through concerned inquiries and by uplifting the family in prayer. Finally, the church has a

unique opportunity to minister to family members who live great distances from the ill persons, but who journey to visit the patients near the end of their lives. Here, the congregation can provide a community away from home, that cares and supports without having to have had a long standing relationship with the families.

Team Work Among Professionals Mandatory

The second principle of hospice care is that teamwork among professionals is mandatory. This principle expands even further the importance of patients' communities to include those professionals, such as doctors, nurses, therapists, and others.

This concept of teamwork among professionals is much harder for the pastor in a congregation to implement. In very few communitites are parish ministers seen as professionals involved in the care of terminally ill persons. Often pastors do not see the doctors, unless the pastor happens to be visiting when the doctor comes by to see the patient. Even then doctors rarely take the time to speak to pastors on a professional level to secure their aid in the care of the patient.

Nursing staff, however, can become very helpful to pastors when they make repeated calls on patients in hospitals. Quite often, as the nursing staff becomes used to an individual pastor stopping at the station and making inquiries about the patient, the staff becomes more open to sharing the

true condition of the patient, and giving the pastor clues as to the emotional condition of family and patient.

Comfort of Patient Goal

Comfort, not cure, of the patient as a goal is the fourth principle that guides the Hospice Philosophy. This principle does not fall within the scope of parish ministry, for ministers are not a part of the prescription of medicine. However, it is not uncommon for a family to seek counsel from their pastor before terminally ill patients decide to allow themselves the benefits of narcotic medicines. In such cases the attitude of the pastor towards suffering will have a large part in deciding how the pastor counsels the family.

Margie has lung cancer brought on by years of smoking cigarettes.[21] Recognizing the cancer was a result of her past actions, Margie began to see the pain she was suffering as a just punishment from God for her actions. She often referred to the pain as the "cross I must bear." Her pastor helped her to see her cancer, not as a punishment from God, but as a natural course of her smoking. The pastor encouraged her not to keep punishing herself, but to forgive herself. The pastor also encouraged Margie to make the most of what life was left to her, accepting that life as a gift from God. If pain-killers were to be a part of her life, then her pastor encouraged her to accept that.

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[21] Name and identifying data have been changed.

CHAPTER 5

A Spiritual Perspective: A Look at Mother Teresa of Calcutta

History

> The tiny grey-eyed woman now known to the world as Mother Teresa of Calcutta . . . was born on the 27th of August, 1910, in Skopje, Yugoslavia, of Albanian parents. Her name was Agnes Gonxha Bejaxhiu.[1]

Agnes grew up in a large, happy, Yugoslavian family. At the age of seventeen, she left her family to become a member of the Irish Order of the Sisters of Loreto. As a novice, Agnes worked in Darjeeling, India, a resort town set in the foothills of the Himalayan mountains. On May 23, 1931, at the age of 21, Agnes took her first vows, and chose the name Teresa.[2]

From Darjeeling, Teresa was sent to the Loreto Convent in Calcutta.

> The Loreto Convent there was surrounded by slums, factories, and the yards of one of the city's garbage dumps. When the wind is wrong, the nauseating stench of neighboring tanneries hangs over everything.[3]

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[1] Kathryn Spink, The Miracle of Love (San Francisco: Harper & Row, 1981), 16.

[2] Eileen Egan, Such a Vision of the Street (Garden City, NY: Doubleday, 1985), 17-18.

[3] Desmond Doig, "Mother Teresa: The Beginning," Catholic Digest 40 (June 1976): 21.

The girls that Teresa taught in Calcutta were not the children of the wealthy, but were mostly orphans, or children of broken marriages, and were racially mixed. Here Teresa took her final vows in 1937. Also on these grounds was a school called St. Mary's, where Bengali girls were taught in their own language. "To this school, first as a teacher and then as its principal" came Mother Teresa.[4]

Mother Teresa, in speaking of her decision to leave the Loreto order and begin an order of her own, wrote:

> It was on the tenth of September 1946, in the train that took me to Darjeeling . . . that I heard the call of God . . . I felt intensly that Jesus wanted me to serve him among the poorest of the poor, the uncared for, the slum dwellers, the abandoned, the homeless. Jesus invited me to serve him and follow him in actual poverty . . . .[5]

But Teresa could not leave the convent without permission. She wrote to the Pope, asking to be released from the Loreto Convent, and to be allowed to set up her own order. Two years passed, and finally word reached Mother Teresa. She was free to start her order. Inscribed in a book of one of India's parish priests are these words:

> On the 18th day of August, 1948, Reverend Mother Teresa is leaving St. Mary's Entally, for Patna. She intends to dedicate herself in the future to the poor and abandoned people living in the slums of Calcutta. For this very difficult work she puts all her confidence in the Immaculate heart of Mary.[6]

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[4] Ibid., 21.

[5] Mother Teresa, My Life for the Poor, eds. Jose' Luis Gonzalez-Baledo and Janet Playfoot, (San Francisco: Harper & Row, 1985), 7.

[6] Doig, "Mother Teresa: The Beginning," 24.

Mother Teresa had realized that her work in the slums would require much more than teaching ability. Nursing and other medical knowledge would be important while working in the slums. To gain this knowledge, she spent a few months in Patna with the medical nuns under the supervision of Mother Dengal. "In December, 1948, Mother Teresa arrived back in Calcutta to be confronted by a city overwhelmed by human need."[7]

Mother Teresa found in the slums a small room she could have, and from there she began her work.

> When Mother returned she was joined by Subhasini Das, who is Sister Agnes, and Magdalen Gomes, now Sister Gertrude . . . . their programme, it was impossible. At 5:30 they were in church. By 7:30 they were already on the streets with their bags working the sweepers' colony, visiting the sick, teaching.[8]

Mother Teresa conceived of a need for the House for the Dying after a moving incident in her life. One day, Mother Teresa found a woman lying on the pavement in Calcutta, dying. She was so desperately ill that she did not notice her feet were being gnawed by rats and cockroaches. Mother Teresa took the woman into the hospital, only to be told because of her ill health and poverty she could not be ad-

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[7] Spink, 23.

[8] Desmond Doig, Mother Teresa: Her People and Her Work (New York: Harper & Row, 1976), 51.

mitted. Mother Teresa's pleading was useless, so she carried her patient to another hospital. Finally, the woman died on the street, where Mother Teresa had found her.[9]

Soon Mother Teresa had people gathering money to start a small home for the dying poor. They called the place Nirmal Hriday, the Place of the Pure Heart. As a rule, when two people were admitted, one patient would die, and one patient would live. Soon the neighbors began complaining because of the smell, so the home was closed.[10]

Mother Teresa then asked the Calcutta Corporation for a place she could use as a home for the dying. Mother Teresa was given an old house near the Temple of Kalighat. She chose the Feast Day of the Immaculate Heart in 1952 as the date that her home for the dying poor would begin operation. There was opposition to the work Mother Teresa and her nuns were doing. Hindus were afraid they were trying to convert people to Christianity. Mother Teresa and her nuns received numerous threats. Local people protested Mother Teresa's home for the dying poor in front of the Calcutta Corporation and the State Assembly. But Mother Teresa had friends in high places who were impressed with her work. Slowly the local people began to accept her.[11]

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[9]Ibid., 54.

[10]Ibid., 59.

[11]Doig, "Mother Teresa: The Beginning," 26.

The Indian women who from the Missionaries of Charity take the

> usual religious vows of poverty, chastity, and obedience plus a fourth most meaningfull of all, the vow of compassion to work exclusively with the destitute, the abandoned, the orphaned, the misshapen, the hopeless, the plague-stricken, lepers, prisoners, and prostitutes.[12]

The home itself was designed for the dying destitute. Only people who have absolutely no one to care for them are allowed to stay. Because of this, "Many people had to be turned away."[13] Half of the patients who enter Kalighat die. The others, who recover, have to return to their life on Calcutta's streets.

> Although it was hard to send them off . . . all patients left with new clothes and a much stronger resistance to the rigors of street life than they had before. And if they fell sick again, they knew they would be cared for.[14]

The patients were well fed, with large quantities of food. "All the rice, milk, eggs, fish, meat and fruit they could eat, with abundant snacks between meals."[15] This good food, in many cases, is the best medicine the patients can receive, because it builds up their resistance to infection. A young woman who volunteered time to the Home described it

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[12] J. J. McCown, "Meet Mother Teresa," Liquorian 65 (May 1977): 34.

[13] Mary Field, "A Volunteer for Mother Teresa," Catholic Digest 42 (December 1977): 70.

[14] Ibid., 71.

[15] Ibid., 71.

this way:

> The Home for the Dying was divided into wards, one for men, one for women. Cooking, cleaning, and sewing, eating and sleeping, nursing and simple companionship, playful banter and sympathy, the resurgence of life and the abandoning of it, all occured in those two long rooms. There was no sense of separation there.[16]

The day for the Sisters begins with prayers and meditation at 4:30 a.m., follwed by Mass. Then each attends to her chores, washing, cooking, mending. Then breakfast, and off they go to their outside duties. Some go to the Home for the Dying, some ride about in the ambulance looking for destitude to pick up; others go to schools or dispensaries; some go to look after lepers, unwanted babies, or children.

Those that go to the Home for the Dying have their work cut out for them. Their first job is washing down the low iron beds covered with plastic mattresses. Pillows and sheets are washed daily. People are fed, cared for, held, and nurtured, all in the name of Christ.

> To soothe those battered old heads, to grasp those poor stumps, to take in one's arms those children consigned to dustbins, because it is his head, as they are his stumps and his children, of whom he said that whosoever received one such child in his name received him.[17]

Love, for the homeless, the unwanted, the dying, here is given out generously. Here may be the last place a dying

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[16] Ibid., 71.

[17] Malcom Muggeridge, Something Beautiful for God (New York: Harper & Row, 1971), 53.

person experiences the joy of human caring. All persons, no matter what their condition, are touched and ministered to. Each, daily, receives a bath:

> . . . a regular festival occurred when the tin of talc was taken around after the daily bath. Some was poured into the outstretched, cupped hands of the ladies. They solemnly puffed it onto their faces, which then remained white-coated till it wore off.[18]

Basic Principles

It is obvious, even just reading how Mother Teresa got started, that her program is not envisioned out of psychological, or sociological, or even humanitarian speculations. Everything that she does comes from theological motives that shake her very being to the core. The most pressing of all her theological urges is the urge to serve, love and honor Christ. This is the prime feeling which causes Mother Teresa to move among the poor. "We (the nuns) take a vow of chastity, of giving our hearts complete and undivided to Christ, and entire dedication to Christ."[19] Serving Christ by serving the poor does three things: (1) it loves God and Christ, (2) it loves the poor, and (3) it loves oneself.

Mother Teresa's first reason for her work on Calcutta is that it loves God and Christ. As she herself writes, "The

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[18] Field, 70.

[19] Muggeridge, 105.

meaning of my life is the love of God".[20] The love of God is also love of Christ. Mother Teresa also writes,

> I have loved Jesus with my whole heart, with my whole being . . . . When I see how the poor remain neglected and unrecognized all around us, I understand the sadness of Christ at not being accepted by his own. Today those who ignore or reject the poor, ignore or reject Christ.[21]

Each day Mother Teresa meets Jesus; in the morning Mass, on the streets, in the House of the Dying, and in every suffering soul she sees and helps. This Jesus, whom she worships at the altar, she also helps in the streets. Mother Teresa writes,

> In the Eucharist I see Christ in the appearance of bread, In the slums, I see Christ in the distressing disguise of the poor. The Eucharist and the poor are but one love for me.[22]

She takes seriously that one who reaches out to the least person in the name of Jesus reaches out to Jesus in person. Her literal acceptance of Jesus' statement, and her great desire to minister to him, gives her the ability to reach out in joyful service to those no one else would have anything to do with before she came along.

Yet, there is more to Mother Teresa than trying to serve God. Although it is impossible to separate the impulses, her serving God is accompanied with an honest desire to help the

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[20] Teresa., 95.

[21] Ibid., 95.

[22] Ibid., 97.

individual who represents God. Her second principle for her work among the poor is that her work loves the poor. Life, every individual human life, is sacred to Mother Teresa, in the full sense of the word.

> Either life is always and in all circumstances sacred, or intrinsically of no account; it is inconceivable that it should be in some cases the one, and in some the other. The God Mother Teresa worships cannot, we are told, see a sparrow fall to the ground without concern.[23]

Each life is sacred to Mother Teresa. Even that life barely existing in a poor, diseased, human body lying in the gutter of Calcutta. Even that life which is passing into after-life is still so precious to her, that it must leave this earth being loved to its fullest. ". . . part of her work of the Sisters is to pick up the dying from the streets of Calcutta . . . (so they may) die within sight of a loving face."[24]

Mother Teresa's love for the homeless and sick extends now into many forms of homes. There are homes for the dying poor, homes for lepers, homes for children. Mother Teresa's Sisters of Charity have houses not only in India, but also in Australia, Bangladesh, England, Kenya, Mauritius, New Guinea, Tanzania, West Bengal, Hong Kong, Japan, New York, and California.[25] Mother Teresa's belief that everyone needs to

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[23] Muggeridge, 29.

[24] Ibid., 41.

[25] Spink, 254f.

be loved is so strong, it extends across all age, economic, geographical, racial and social barriers. Mother Teresa, in defending her practice of taking in babies who were born prematurely, or who survived attempted abortions, stated,

> I don't care what people say about the death rate (of the babies). Even if they die an hour later we must let them come. These babies must not die uncared for and unloved, because even a tiny baby can feel.[26]

Love, the act of ministering to and caring for an individual is central to the work Mother Teresa does. Just as God receives this love when it is bestowed upon the dying by one of the sisters, so the love of God is received by individuals who receive the love of the nun who ministers to them. Somehow, Mother Teresa has overcome the tension between ministering to the dying just because Christ ordered it, and ministering to the dying because they are human beings. For Mother Teresa, both feelings are inseparable.

Her desires for the poor can be summed up in one of her simple prayers,

> Make us worthy, Lord, to serve our fellow men throughout the world who live and die in poverty and hunger.
> Give them through our hands this day our daily bread, and by understanding love, give peace and joy.[27]

Yet all is not for God and for the ill. Some of the working and serving of others fulfills Mother Teresa's third

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[26] Ibid., 50f.

[27] Muggeridge, 39.

principle, that her work loves self. Mother Teresa said, "I couldn't meet God if I didn't do this work."[28] Not only does Mother Teresa want to serve God and serve the ill, but she wants for herself the joys that come from giving oneself wholly to God. She wants to meet God in her life, and believes she benefits by helping the poor. When a young woman volunteered to help the Missionaries of Charity, Mother Teresa wrote this reply,

> We do not need you to work for us, as we have many helpers. But if you want to be enriched by your loving service of Christ in his distressing disguise of the suffering poor, you are most welcome any time you wish.[29]

Mother Teresa knows her life has been enriched by her service of Christ. She rejoices that he has so much for her to do, and can use her so readily. By getting in touch with the people she has gotten in touch with God.

For Mother Teresa, the commandments to love God and to love neighbor as one loves self, are jointly fulfilled. In her life, she shows the two cannot be separated: if we do not love our neighbor we cannot love God, and if we do not love God we cannot love neighbor. Moreover, she shows that by loving God and neighbor, one actually ends up loving and fulfilling self.

In our day and age when suffering is often hidden, and

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[28] Doig, "Mother Teresa: The Beginning," 22.

[29] Field, 69.

doctors are to be the Messiahs who save us from death, Mother Teresa has a different view.

> Suffering and death, to her, are not the breakdown of a machine, but part of the everlasting drama of our relationship with our creator. Far from being an unjustifiable violation, an outrage, they exemplify and enhance our human condition. If ever it were possible, as some arrogant contemporary minds are crazy enough to believe, to eliminate suffering, and ultimately death, from our mortal lives, they would not thereby be enhanced, but rather demeaned, to the point that they would become too insignificant, too banal, to be worth living at all.[30]

Malcom Muggeridge, after interviewing Mother Teresa on British T.V., received hundreds of letters. About these letters, he said,

> I was conscious, turning over these letters, more poignantly than ever before, of how all of us are at one, if not in our hopes and desires, then in the scars and bruises we bear, or have watched with anguish being inflicted on some beloved mind, bringing down the darkness upon it. We can still gather together round the Cross even though we shut our ears to the words of the Man who died on it.[31]

Evaluation and Application of Principles

Loves God and Christ

Serving the terminally ill is loving God and Christ is the first principle that motivates the work of Mother Teresa of Calcutta. Such a belief is grounded in the theological conviction that the very nature and substance of God is love. God's intense love and God's responsiveness to individuals

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[30] Muggeridge, 131-132.

[31] Ibid., 133.

brings God to a close identification with those who suffer. To reach out to the dying loves God in two ways. Reaching out to the dying loves God because it seeks to do the work that God desires to be done. Reaching out to the dying also loves God because it ministers to those with whom God has a close identification, and hence ministers to God.

Belief that serving the terminally ill is loving God and Christ is also deeply rooted in the teachings of Christ from the Gospels. Illustrative of this is the vision of the Last Judgment as told by Jesus and found in the Gospel of Matthew. In the scripture, Jesus speaks of the Son of Man coming to earth and gathering the nations of the world before him.

> . .. and he will place the sheep at his right hand, but the goats at the left. Then the King will say to those at his right hand, "Come, O blessed of my Father, inherit the kingdom prepared for you from the foundation of the world; for I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me. . . . `Truly say to you, as you did it to one of the least of these, my brethren, you did it to me."[32]

The scripture continues in the same form, only the goats are placed on the King's left side and condemned for not serving the needy. The King concludes to the goats on the left, "Truly, I say to you, as you did it not to one of these, you did it not to me."[33] From the beginning of the

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[32] Matthew 25:33-40 (RSV).

[33] Matthew 25:45b (RSV).

Christian Faith, there have been those followers who have placed emphasis on serving the poor and ill as means of serving and loving God and Christ.

Seeing God and Christ in the poor and ill does not imply an identity of individuals and the divine such as the Hindu or Buddhist theologies have taught. In each of these religions the focus of religious practice is to untrap the spirit from continuous reincarnation so it can be absorbed and lose its separate existence through Moksha or Nirvana. Moksha or Nirvana are eternal states of non-being, where individuality is lost, and the self resumes its rightful place in the one reality, just as a single drop of water loses its identity in the vast ocean.

The Christian Faith has taught that human identity is separate from that of the Divine identity. God is Creator of the world, and Creator of human life. Time and time again the Biblical witness calls the people of the faith to return to the faithful witness of their Creator.

One can maintain the distinctness of identity between God and people and still maintain along with Mother Teresa that Christ comes to her in the faces of the poor, and that serving the terminally ill is, in fact, ministering to God. The God who is responsive to people is responsive to the poor in Calcutta who lay by the sides of the streets waiting for death to take them. This God, who rejoices with those who rejoice, is glad when these poor are taken into the clean,

well-ordered houses Mother Teresa runs, and are given food, clean beds, and loving care. Even though human identity is different from God's, this God who notices even when a sparrow falls, is effected, served, and loved when people in need are ministered to.

Loves the Poor

Mother Teresa's second principle, that helping the terminally ill is loving them may sound redundant. Yet, when this sentence is turned around, it becomes a motivating force for working with those who suffer. Turned around, the sentence says, to love the terminally ill is to serve them. A motivating force for ministry to the terminally ill is the genuine love and concern pastors feel for individuals. Such love is not a romantic idealization of the ill and their sufferings. Instead, the Christian love that seeks to empower ministry endeavors to be a reflection of the responsive love of God.

When Mother Teresa speaks of loving the poor and suffering in India, she means according to them every possible human dignity available during their dying or healing moments. They are fed good food, they are cared for, given medicine, a clean bed to sleep on, time from the nuns who work for them, and they are held and comforted.

Ministers who work in the parish find their situation different from that of Mother Teresa and the Sisters of Mercy. While sometimes ministers first meet a patient during

the final stages of life, more frequently parish ministers find themselves ministering to terminally ill persons they know from their own congregation. As pastors love these patients, they become aware of them as complex human beings with needs caused by their illnesses, and with other needs caused by other factors in their lives, i.e., family, job, finances. The task of parish ministers is not to focus on the terminally ill in their congregation, but to focus on the people in their congregation, some of whom will find their lives affected one way or another by a terminal illness, either their own, or that of a member of their family.

As the illness progresses, it fills more and more of the patients' lives and finally becomes the dominant factor in the lives of the patients and their families. Pastors are still called to meet openly with the terminally ill about their families and to love them during the critical final months in their lives. Such months are often filled with intense emotion and need for pastoral influence to give direction and hope.

It can be tricky to use the word "love" to speak about the dealings pastors have with people in their parishes. A helpful definition of love that comes from Webster is

> unselfish concern that freely accepts another in loyalty and seeks his good: (1): the fatherly concern of God for man (2): brotherly concern for others.[34]

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[34] "Love," Webster's Seventh New Collegiate Dictionary.

Another way to conceive of "love" is to look at what God intends for people. God wishes for each person maturity, and wishes for each person to strive towards the goal of greatest spiritual growth in all stages of life, including death. Such a definition of love highly individualizes the way pastors will work with terminally ill patients. People are all in a different stage of growth as far as their spiritual journey is concerned. Some patients will need to learn to express anger, others will need to learn to express love. The possibilities are limitless. Pastors are in the position (as is everyone) of opening themselves to allow God to work with them and through them to effect change in the patients' lives.

Angela is a young woman suffering from a painful cancer that has an unpredictable course.[35] Treatment will not reduce the size of the tumor, but it seems to slow the growth. The cancer may stabilize for 10 years, or it may explode, causing instant death. Even if the cancer stabilizes, its effects are painful and limit severely Angela's activities.

Angela came from a home environment where she was taught she was worthless, and no one could ever care about her. Yet, as her cancer became worse, she sought the advice of a minister, and was surprised by the ready acceptance and help

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[35]Name and identifying data have been changed.

she received.

Time and time again Angela would ask why the pastor would spend so much time and do so much for a worthless person. As the pastor communicated God's love for Angela, she began to find hope. Not hope that her illness would get better (though she always hoped for that), but hope that God really cared about her. Hope that she really was not a bad person, and that her illness was not God's way of punishing her for past misdeeds. Her history was such that she had a lot of negative input from her parents to fight, and yet, even with all she had been taught concerning her own worthlessness, once she had been told God loved her, she never let go of that hope. She may have questioned that hope at times, and sought to receive reassurance from her pastor and church friends, yet that hope remained, strong and powerful.

As Angela grew in her own understanding of self (and she grew rapidly spurred by her knowledge of what a short time she had left to live), she dared to ask more of her minister. Quickly, it wasn't enough that the minister helped her because God loved her, Angela needed the reassurance that people could love her too. The minister was able to share not only God's love for Angela, but her own love and hopes for Angela. This joining together of Mother Teresa's first two principles, ministry to the terminally ill loves God and Christ, and it loves the ill person, helped Angela to come to a greater acceptance of herself.

Loves Self

Mother Teresa's third principle, that by ministering to the terminally ill (loving God and loving others) one loves and fulfills self. Such an idea fits well with a theology of maturation. God wills for each individual to grow into an attitude of maturing other-interestedness. The two greatest commandments Christ noted, the two greatest steps towards spiritual maturity, are,

> You shall love the Lord your God with all your heart, and all your soul, and with all your mind . . . You shall love your neighbor as yourself.[36]

Growing in spiritual maturity is an act of self love. It allows the individual to come to a greater acceptance of self, and a greater understanding of self. To work for the good of others, that their lives may be enriched and their spiritual perception enhanced deepens and enhances one's own spiritual perception.

Working with the terminally ill has an added dimension beyond helping others mature spiritually. It has the dimension, by the very nature of working with those who are dying, of making pastors come face to face with the issues of life and death. It is easy to assume that our lives will continue at the nice, steady pace they always have had for, well, almost forever. Working with the terminally ill reminds us that life can be capricious, good one moment, bad the next.

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[36] Matthew 13:37b-39 (RSV).

Such work reminds us that life is precious, a gift to be enjoyed, not squandered. Working with ill persons, watching them cling tenaciously to life, when it would be easier to give up, teaches the value of life in the most difficult situations.

Working with the terminally ill can send one's emotions through the entire gamut. Pastors, along with their parishoners, will find themselves mired in depression and clinging to hope. They will witness the depths of the human spirit, and the victories it can achieve. Such a life, that seeks not to hide from the sorrows and joys of others, will find its own sorrows and joys shared by the community it has established. There are benefits pastors can reap by working with those who are terminally ill, all of which work towards spiritual maturity, and hence, are self-loving.

The work of Mother Teresa among the poor and destitute of India, and across the world, can shed much light on the work pastors do with those in their congregation who suffer. Study of Mother Teresa and Sisters of Charity can lend insight and inspiration and hope as pastors face the needs and concerns of those who are terminally ill.

CHAPTER 6

Principles for Parish Ministry

A theology that is responsive to the needs of the terminally ill must be based, first, on the belief that love is the very nature and substance of God. This belief is expanded through the identification of God's responsiveness to individuals in all situations of their lives. Finally, the theology seeks to find God's grace that reaches out to individuals and serves as the catalytic change agent in their lives.

This theological basis then informs and evaluates the body of knowledge that has been formed concerning work with the terminally ill. As this theology and the sociological/psychological work interface, one can discover principles for ministry to the terminally ill that can inform and direct the work of parish ministers.

Steadfastness and Love of God in All Situations

It seems almost trivial to say that suffering a terminal illness is a terrible thing. The words, however, speak more than they seem to be saying. Suffering a terminal illness is a terrible thing physically. It destroys the functioning of different parts of the body. It can cause people's appearance to change. Ultimately, it brings an end to physical

life.

Suffering a terminal illness is also a terrible thing emotionally. It causes depressions of varying strengths and lengths, and it causes people to ask questions that search the innermost parts of being. Such questions include "Why did this happen to me?" "Why is God punishing me?" "Is God testing my faith?" "Why doesn't God answer my prayers and heal me?" People with terminal illness, who go through depressions, find themselves searching and questioning the very ideas and concepts that they previously held about the world, about themselves, and about God.

It is to people questioning and suffering that pastors bring the word that God's love and strength is available in all situations, that even as people lose the power of their bodies and their ability to remain healthy, God is there as a loving presence. In the times when pain is felt, and nothing else can be thought about but that pain, God is there as a loving presence. In those moments when patients feel themselves unloving and unlovable, God's loving presence is there. Even when patients question the very existence and presence of God, God is still there, loving and seeking to give strength and comfort.

As patients begin to accept that illness is not punishment for past misdeeds, and as they begin to accept that God is truly loving and really continues to love them, they become open to the effects belief in a loving God has. First,

they begin to accept themselves. It is hard for people suffering an illness, who feel loss of control of their lives, to accept the people they find themselves becoming. They struggle to remain their healthy selves. They seek to keep up their work schedules, their family schedules, their school, leisure, or play schedules.

Pastors who are willing, as Kuebler-Ross suggests, to learn what the dying patient needs from the dying patient, will find patients expressing their self doubt, and their doubts concerning the existence of a loving God. It can become the pastor's privilege to help patients discover for themselves, the love of God that is there for all people, including themselves. Mother Teresa believes serving the dying loves God and Christ. It follows logically from that statement, that the loving presence of ministers who seek to serve the terminally ill has the possibility of becoming a symbol of the continuing love and presence of God through the ordeal of illness.

The question that emerges from discussion of this principle is the basic question of "How?" How can ministers meet with individuals who are suffering pain, loss of self-esteem, and even loss of life, and convey to them that God is a loving God? How do pastors enter a household, where the family has just learned that a child is dying of leukemia, and speak of the loving presence of God? How do pastors enter a hospital room, where a woman is bloated from cancer,

bald from chemotherapy, and lonely because friends won't come and visit; and say that God loves her?

This "How?" question is not an easy question to answer, and often the answer to "How?" must be left to the discerning care of pastors who seek to be instruments of God's love to these people. Here is where Kueber-Ross's idea of learning what the patient needs from the patient can be effective. If pastors wait long enough, and visit enough times, with an openness to these people, they will find that these patients often let pastors know what they need. Some people need to hear the words, simply stated, that God still cares for them, and that God is not punishing them. Others need to hear of God's presence, helping them to face ordeals that might lie ahead. Still others may not appreciate words. Instead, they welcome the quiet presence of ministers who come just to share time. They welcome their pastor's touch, a holding of hands, a hand on the shoulder, a hug that comforts when tears fall.

One ally for pastors as they seek to communicate the love of God to terminally ill persons is time. It may seem contradictory to think of time as an ally in ministering to the terminally ill, but it is the knowledge of lack of time that can be of such great help to pastors in their ministry. Terminally ill persons, who have begun to come to terms with their death, and see their days as limited, begin to explore their faith and their life in ways they may not have while

they were healthy. Patients hunger to come to a resolution of their faith, and a deeper understanding of God before they die. Therefore, they are open to the input that their ministers give concerning the love and steadfastness of God in all situations.

Minister to Those Within Their Sphere of Influence

The Hospice Movement, as one of it's basic principles, puts forth the concept that patients and their families are the unit of care. From the very first interview with a patient, until after the patient's death, Hospice seeks to provide support, counseling, and care for the family members who are dealing with the death of a loved one. Kuebler-Ross, upon leaving her position at the University Hospital in Chicago, did workshops that included not only terminally ill persons, but also persons who had had family members die, and persons who had family members who were dying.

The effects of a terminal illness cannot be confined to the terminally ill person. Like the ripples on the water after a rock has been thrown into a lake, the effects of a terminal illness spread outward from patients, to their family, their friends, and their co-workers. The ripples, instead of flowing in nice, even, concentric circles, flow unevenly. Sometimes their effect is felt strongly by one relative, while another relative may seem barely touched.

It is not hard, for ministers who are in touch with their parishoners, to know of several families who are being

affected by the illness of someone. One family in the church has a member of the nuclear family hospitalized, diagnosed with cancer. An elderly person may have a sibling who lives 2,000 miles away, who is in a nursing home, and dying. Sometimes there is an untimely death of a child within a congregation, and the entire congregation joins in mourning and bereavement following the death. Here and there, within the congregation, are people who are struggling with questions and emotions, grief and loneliness following the death of another person.

Pastors who base their ministry on God's responsiveness to all people's joys and sorrows will seek to be instruments of that responsiveness whenever the opportunity arises. They will seek to minister to the terminally ill. They will also seek to serve as God's instruments of love to the family and friends, who are experiencing the grief, anger, denial, or acceptance of another's illness or death.

Realistically, this principle concerning pastors reaching out in love to others has its human limitations. Pastors are human beings, who find many demands on their lives, demands that often are of high importance, but are conflicting because of time available to perform the ministerial task. Each individual pastor must seek ways to minister to those who are bereaved or dying in such a way that their entire ministry maintains balance.

Clergy also need to be realistic about their sphere of

influence. Sometimes clergy are called to do funerals for people whom they have never met and whose families they do not know. There is no doubt that when pastors perform these funerals they are performing an important ministry to the family at the time of bereavement. However, when they attempt follow-up calls on the family, they are sometimes rebuffed. It becomes apparent that the family has no desire to continue to be in contact with the minister who has performed the service. Clearly, the family is no longer within the sphere of influence of the minister and has no desire to be in that sphere of influence. Wise ministers will recognize where their attentions are not wanted and will turn their energies elsewhere.

Quest for Spiritual Maturity

The power of God at work in this world is the power to effect change, to call people out of their own self-interest into an attitude of maturing other interestedness. People who undertake the quest for spiritual maturity undertake the quest for acceptance of God's love in and through all situations. They accept the quest to live that love that empowers their lives. This "experience of spiritual power is basically a joyful one . . . Those who have grown the most spiritually are those who are the experts at living."[1]

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[1]M. Scott Peck, The Road Less Traveled: A New Psychology of Love, Traditional Values and Spiritual Growth (New York: Touchstone/Simon & Schuster, 1978), 286.

Those who quest for spiritual maturity seek to accept God's love for themselves. Having accepted God's love, they seek to live that love as an instrument of the Divine Love. As they grow, they look for ways for others to mature spiritually, that they too may accept the grace God offers so freely. Clergy, then, who seek spiritual maturity find themselves on a double path, as they seek their own maturity, and as they seek to promote the maturity of others.

For Self

The third principle that determines the work of Kuebler-Ross is that working with the terminally ill benefits those that work with them. Mother Teresa expresses the same philosophy when she states that working with the terminally ill loves self. Pastors who work openly and lovingly with the terminally ill will find their own lives enriched.

By stating that pastors' lives will be enriched by ministry to their terminally ill, no syrupy sentimentality is intended. Work with the terminally ill is difficult at times, calling pastors to exert every ounce of expertise they have. The terminally ill, after all, are human beings who experience every level of human emotion. That emotion may be magnified by the existence of that illness, but those emotions are the same. Hence, there are times when the terminally ill can be cantankerous, argumentative, or uncommunicative. They can desire to be left alone, expressing little, if any, interest in the visits from their pastor. It

can be difficult for pastors to speak with family members who are grieving too deeply to talk, or who are in such a state of denial, they just don't want to be bothered.

It is sometimes difficult to work with the terminally ill and their families. Yet, even when it is difficult, it can be rewarding to continue working with the them. The mere knowledge of attempting a difficult task can reward the pastor.

The reward that pastors experience goes beyond the accomplishment of a difficult task. Honestly facing all of life head-on brings maturity and wisdom. Since "Death is a normal phase in the life cycle,"[2] learning to accept death brings maturity and wisdom.

Part of spiritual maturity is the ability to rejoice with others' joys, and to suffer with others' sufferings. It is the quality of being "in life" with others, and sharing their experiences, just as God is "in life" with people, and shares their experiences. Such caring ministers are open to sharing the love of God, even though their caring is but a mere shadow of God's caring.

The growth of spiritual maturity through ministry to the terminally ill opens ministers up to the lives of others. It also opens them up to the heart and mind of God, as they experience some of what God experiences. As pastors live with

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[2] Koff, 70.

the dying and their families, they learn to love others as God first loved them.

For Others

> Spiritual competence may increase . . . until the moment of death in advanced old age. Our lifetime offers us unlimited opportunities for growth until the end.[3]

Opportunities to mature spiritually do not end with the onset of a terminal illness. Each person, as a recipient of God's grace, has opportunities to mature and grow towards the goals that God creates. As pastors "love the terminally ill" (Mother Teresa's second principle) by reaching out in ministry to them, those pastors will seek to aid the spiritual growth of the ill and their families.

The problem for pastors arises in trying to determine what spiritual growth is for patients and their families. Here, Kuebler-Ross' instructions to learn what the dying person needs from the dying person can be enlightening. People are all at different points in their spiritual journey. Illustrative of this is Kuebler-Ross' stages of grief, stages that move from denial to acceptance. Patients can be found in any of the five stages of grief. Attentiveness to the patients also shows that they do not remain in the same stage. They can advance and retreat along the levels of grief, or skip over one stage completely. Pastors who listen know they need to be constantly aware of the stage patients

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[3] Peck, The Road Less Traveled, 263.

and families are in, so they can better minister to them.

Just as pastors can be aware of stages of grief, so also they can be aware of the spiritual condition of those to whom they are ministering. As people near the end of an illness, they sometimes evidence difficulties with their own death. Sometimes, there are family members from whom they have been alienated. Sometimes, they express concern over past "sins." Discerning pastors will help the ill resolve spiritual conflicts they have, so there is one less burden on their minds.

As pastors work to foster the spiritual growth of the dying, they need to be careful not to be judgmental. They need to be careful not to communicate abhorrence to any individual's spiritual condition. Since the terminally ill are already struggling with issues of self-acceptance, pastors need to express God's love and acceptance, and to model God's love with their own love.

Being careful not to judge does not preclude expressing concern about an individual's spiritual growth. Since no one is perfect, there is always room for deeper self-acceptance, acceptance of others, and acceptance of God's grace.

When various members of the family are at widely different stages of maturity, the pastor's role can be especially difficult. Sometimes pastors have to deal with ill persons seeking forgiveness from family members for some past transgression. This quest for forgiveness can be stymied if the family members are not ready to let go of their hurt or

disappointment.

Pastor is Presence For Worshipping Community

When pastors visit the terminally ill who have been members of their congregation, they represent the entire community of faith. Often, as illness progresses, it is impossible for members of the congregation to come and visit the terminally ill. Often this is not because these people don't want to visit. Instead, the terminally ill are unable to sustain long visits from their friends, or unable to see as many of their friends as they would like.

"The spiritual component of the personality is bound up in relationships, the relationship to self, to other, to God."[4] Pastors who are aware of the importance of relationships to others will seek ways to keep those relationships alive. Sometimes pastors bring messages from other members of the congregation. Sometimes they bring a part of the worship service that is familiar to the ill person (i.e., worship bulletin, taped music, a prayer from the service).

Both the Hospice Movement and Kuebler-Ross stress the importance of community. These disciplines seek to provide community to the terminally ill and their families so that life is not diminished during the final months or days.

As pastors find themselves representing the worshipping community, they find themselves representing more than just

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[4] Koff, 71.

individuals. The Church is much more than a group of people who gather together sometimes. The Church is constituted of people who worship God, and seek to live as God calls them to live. Pastors, who share sympathy and news from the congregation share the responsiveness of the community of faith towards those who are suffering and dying.

The representation, however, does not stop with the congregation. Just as the pastor represents the worshipping community, so does knowledge that the community cares represent the caring responsiveness of God for the ill. This capacity is given to ministers, not because of who they are as individuals, but because of the office they have assumed. Simply being "minister" opens many avenues of service that others without the title don't find readily available. The office of minister, however, is not enough on its own to represent the Community of Faith, or the love of God. Uncaring, inept ministers can quickly shut the doors that were open to them because of their title. Ministers need to be constantly aware that it is a privilege to represent the Community of Faith and the love of God, remembering that privilege can help them to be careful in the tasks they undertake.

Hope

Hope can be one of the most powerful personal forces in the world. It is hope that keeps farmers on the land during a long dry drought. It is hope that helps parents raise children from infants to adults. Hope raises a lofty pos-

sibility and makes that possibility seem attainable.

Hope is a mysterious force that gives strength, even when there seems no logical reason to hope. As terminally ill people advance through the stages of grief, they come to the point of acceptance. They accept their illness, they accept the inevitable outcome. They become willing to live, and to die, with their disease. Even as they gain acceptance of their illness, they never lose hope. Even until the moment of death, some hope that the impossible will happen. They hope for a last minute remission, or that science will discover a miraculous cure.

Paul wrote that "faith is the assurance of things hoped for."[5] Hope is, in fact, the very foundation upon which faith is built. Pastors can revive hope in the terminally ill, even when certainties fail. They bring hope that God truly loves everyone, in spite of the illness that afflicts the sufferer. Pastors bring hope that ultimately life is good, and a gift from God. They bring hope that indeed "life and death are one,"[6] encouraging the ill to find hope in the premises of eternal life.

This is not to imply that the hope in life eternal is to be used as a panacea for the terminally ill. Too much talk about the after life can be an easy way to avoid the

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[5] Hebrews 11:1a (RSV).

[6] Kahlil Gibran, The Prophet (1923; reprint, New York: Knopf, 1939): 87.

patients' sufferings in the here and now. Hope in life eternal gains importance and strength as it becomes the hope that is left as life begins to dim.

Conclusion

> My soul spoke to me and said, "The lantern which you carry is not yours, and the song that you sing was not composed within your heart, for even if you bear the light, you are not the light, and even if you are a lute fastened with strings, you are not the lute player."[7]

Ministers need to remember, at all times, that ministry is service to God. Therefore, they do not enter into the task of ministering to the terminally ill alone. It is a difficult task, often heartbreaking as patients and families deal with life and death issues. It is also rewarding, to bring hope and faith in the midst of suffering and crises.

Ministers also need to remember that ministry (service to God) is not confined to ministers. Pastors who serve with an open heart, and a willingness to learn from their parishoners, will find that the terminally ill minister to pastors as much as pastors minister to the terminally ill.

The greatest source of strength for ministers who pastor those who are afflicted with illness is this: That the God who reaches out to the terminally ill with loving responsiveness extends that same love to the ministers. It can be a great comfort, during moments of doubt and confusion, to

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[7] Kahlil Gibran, Thoughts and Meditations, ed. and trans. Anthony R. Ferris, 4th paperbound ed. (New York: Citadel, 1969): 32.

remember God is there, and God supports and guides the work of pastors who seek that guidance.

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